Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALLIED MEDICAL CENTERS
PO BOX 24809
HOUSTON TX 77029

Respondent Name
AMERICAN HOME ASSURANCE CO

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-11-1817-01

MFDR Date Received
February 7, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our doctors usually spend 45-60 minutes conducting an evaluation of new patients. As noted in the typed subsequent report that was submitted with the HCFA billing, you can clearly note that a comprehensive history is documented under Present Medical Condition on our follow-up exam form. A comprehensive examination including neuro & ortho exams were also performed and documented in the exam form. Decision making of moderate complexity was also met and documented in the treatment plan. Plan is noted in the report as well as discussing current medication and referral recommendations."

Amount in Dispute: $425.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The notes do not appear to have all 3 components present for procedure 99205 mentioned above and procedure 99354 is included/bundled within the value of another service and therefore, no additional payment is recommended at this time."

Response Submitted by: Hoffman Kelley

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 2, 2010	99205 and 99354	$425.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate
   - 589 – The documentation received does not support the level of service billed. Please adjust the level of service billed or provide...
   - 107 – Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim
   - 246 – This procedure is inappropriately billed. It should only be billed in conjunction with appropriate required code
   - 18 – Duplicate claim/service
   - 247 – A payment or denial has already been recommended for this service
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time
   - 5081 – Reduction or denial of payment resulting after a reconsideration was completed
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c) (1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute."

   The date of the services in dispute is February 2, 2010. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on February 7, 2011. This date is later than one year after the date(s) of service in dispute.

   Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 17, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.